	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE COMPI 07/11/2	LETED
NAME OF PROVIDER OR SUPPLIER MONROE HOUSE				2770 S	ADAMS RD IINGTON, IN47403		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
R0000	(PSR) to the PSF the State Resider completed on 02 Survey Date: 07 Facility Number Provider Numbe Aim Number: Survey Team: Melinda Lewis F Marla Potts RN Census by Bed T	7/11/11 : 004016 r: 004016 NA	RO	0000	Submission of this response an of Correction is NOT a legal admission that a deficiency exithat this Statement of Deficient was correctly cited, and is also to be construed as an admission against interest by the residence any employees, agents, or othe individuals who drafted or may discussed in the response or Pl Correction. In addition, preparand submission of this Plan of Correction does NOT constitut admission or agreement of any by the facility of the truth of an facts alleged or the correctness any conclusions set forth in this allegation by the survey agence.	sts or, cies NOT n e, or r be an of ation e an kind ny of s	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 1ZTC13 Facility ID: 004016

PRINTED: 07/29/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/11/2011
	PROVIDER OR SUPPLIER		2770 S	ADDRESS, CITY, STATE, ZIP CODE ADAMS RD MINGTON, IN47403	
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	Census by Payor Other: 35 Total: 35 Sample: 03 These State Resin accordance with	dential findings are cited th 410 IAC 16.2-5.			
R0052	(1) sexual abuse; (2) physical abuse (3) mental abuse; (4) corporal punish (5) neglect; and (6) involuntary sec Based on observer record review, the implement a plan known risk of elections.	elusion. ation, interview and e facility failed to a for a resident with a ppement from exiting the residents reviewed for	R0052	Citation #1 IDR Request face face meeting R 052 410 IAC 16.2-5-1.2 (v) (1-6) Resident Rights We respectfully diagr with this citation and Have requested an Informal Dispuresolution meeting. This Plar Correction is being provided	s' ee te n of

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´			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00		00	COMPLETED	
			B. WING			07/11/2011	
<u> </u>					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			2770 S	ADAMS RD		
MONRO	E HOUSE			1	MINGTON, IN47403		
		TATEL OF DEPLOYENCIES			,	-	(115)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA	TΕ	DATE
IAG		ESC IDENTIFTING INFORMATION)	+	IAU	required by state law What		DATE
	Resident # 1				required by state law. What corrective action(s) will be		
					accomplished for those		
	Findings include:				residents found to have be	en	
					affected by this deficient	···	
	On 7/11/11 at 10:	:30 A.M., Resident # 1			practice? No residents were	.	
	was observed in l	his apartment. During			found to be affected. Reside		
		time, Resident # 1 was			entered our community and	was	
		e current date, day of the			assessed by a licensed nurs		
					found to be alert and oriente		
	, i	ot able to state location			person, place, and time with	а	
	prior to moving t	o this facility.			mini mental score of 29.		
					Resident's physician prior to admission felt resident was	'	
	The clinical recor	rd for Resident # 1 was			cognitively able to self admir	nister	
	reviewed on 7/11	/11 at 10:00 a.m. The			medications based upon his		
	record indicated	Resident # 1 had			assessment and knowledge		
		included, but were not			the resident's medical		
	limited to, cogni	·			condition. Resident is capab		
	innica to, cogin	tive deficit.			making his own decisions ba	ased	
	A 12 / / 1 1 2				on clinical observation and		
		eian office visit, dated			documentation provided. Aft Resident #1 went outside or		
	· ·	d "Patient here to			28, 2011 the Wellness Direc		
	follow-up cogniti	ive deficitHe may be			had a urinalysis and blood w		
	mildly better, He	seems to be thinking			ordered to rule out acute car		
	better"				changes related to a potential	al	
					"significant change" due to		
	The Service Asse	essment/Negotiated			intermittent confusion. Moni		
		ed 6/22/11, indicated			House has began to adminis		
	-	ait seeking fairly easy to			medication for this resident umedical evaluation by the	untii a	
					resident's attending physicia	ın is	
	reorient 15 min c	neck			completed. Sign posted at		
					Residence in entry way asks	,	
		vith the Admission			visitors not to let residents e	nter	
	Coordinator, on 7	7/11/11 at 1:30 P.M., she			or exit community without st		
	indicated the serv	vice			knowledge. Signage was po		
	assessment/negot	tiated service plan, dated			on the doorway upon entering		
		form that was used			and exiting the building in ef		
	· ·				minimize the risk for exit see behaviors for those residents	- 1	
during the preadmission evaluation. She					Deliaviors for those resident	٥	

004016

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 07/11/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2770 S ADAMS RD MONROE HOUSE **BLOOMINGTON, IN47403** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE considered to be "at risk." Even stated that the previous Wellness Director though Monroe House does not and herself had done the assessment of consider resident #1 to be an exit Resident # 1 together. seeker Monroe House has alerts in place such as the updated service level assessment and The Discharge Checklist, dated 6/24/11, negotiated service plan for this indicated "...Pt [patient] currently on 15 individual to include services min [minute] checks due to elopement rendered by our staff to ensure risk..." the resident's scheduled and unscheduled needs. How the facility will identify other The Resident Services Notes, 6/28/11 residents having the potential 0900 (9:00 A.M.), indicated "Local repair to be affected by the same man let resident out of facility upon deficient practice and what entering. Res [resident] was seen leaving corrective action will be taken? facility by Activity Director (name) and No other residents were found to be affected. Residents was immediately escorted back into considered "at risk" for exit building. This RN assessed res upon seeking behavior were re-entry, no injuries. Family and MD re-evaluated by a licensed nurse notified." utilizing our service level assessment and negotiated service plan with interventions The Elopement Risk Assessment, dated implemented to minimize the risk 6/29/11, indicated "...Past history of for future behaviors. What elopement or exit seeking behavior, measures will be put into place or what systemic changes will Change in usual orientation, confusion, the facility make to ensure that agitation or pattern of wandering, the deficient practice does not disorientation or intermittent recur? The new Wellness confusion...Any bold item- Even one of Director and Residence these items indicates a potential for Director were educated to our policy and procedure regarding elopement and requires consultation with our service level assessment, the regional team and appropriate elopement protocol, task sheets, intervention..." Two of the and Behavioral Management circumstances/behaviors identified were Plan. Residents considered "at risk" for exit seeking and/or bold. elopement behaviors will be carefully evaluated with In an interview with RN # 1, on 7/11/11 at

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 07/11/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2770 S ADAMS RD MONROE HOUSE **BLOOMINGTON, IN47403** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 10:15 A.M., she indicated Resident # 1 interventions developed and Implemented in effort to minimize was observed by the Activity Director the risk for potential behavioral outside in the parking lot. She indicated disturbance. Residents will be the Activity Director was not sure if the identified via the task sheet with interventions provided on the person observed in the parking lot was a service plan. How will the resident or not, but she assumed he was a corrective action(s) will be new admission as he was going from car monitored to ensure the to car. deficient practice will not recur, i.e., what quality assurance program will be put into place? In an interview with the Regional Nurse, The Wellness Director will on 7/11/11 at 11:30 A.M., he indicated perform a random monthly review when Resident # 1 eloped on 6/28/11 the of residents at the Monroe House facility talked with the vendors and for a period of six months to instructed them not to let residents out the ensure residents considered "at risk" for exit seeking and/or doors. He further indicated there had been elopement are adequately a sign on the door to inform visitors and assessed with interventions vendors not to assist residents outside. He developed to minimize the risk for further indicated Resident # 1's behavior behavioral disturbance through utilization of the service level was new and he had contacted the assessment and task sheets. physician himself. Findings will be reviewed within six months to determine ongoing A Physician Fax Transmission/Phone monitoring plan. Findings suggestive of compliance will Order, dated 6/30/11, indicated "...Family result in no need for routine and writer has observed some change in monitoring per our plan. By what this residents condition. Resident came to date will the systemic changes us alert and oriented x [times] 3 and well be completed? Compliance able to manage medications after being Date: 8/24/11 set up in med [medication] planner by daughter due to change I have removed med planner contacted family and am administering meds. May we do a U/A [urinalysis]?..." A Fax Error Report, dated 6/30/11 at 11:32 (no A.M. or P.M.), indicated "...Busy/No signal..."

Facility ID:

I			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
			B. WIN	IG		07/11/2	U11
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
				1	ADAMS RD		
MONRO	E HOUSE			BLOOM	MINGTON, IN47403		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENC!)		DATE
	0:: 7/11/11 -4 13	20 D.M. 4h a autom					
		:30 P.M., the entry way					
		the posting of a sign to					
		ot to assist residents					
		as a sign observed					
	" "	e key pad to exit the					
		there was no other signs					
		m visitors upon entering					
	the facility not to	assist residents outside.					
	On 7/11/11 at 1:1	5 P.M., in an interview					
		e indicated Resident # 1					
		ry 30 minutes for his					
		icated these checks had					
		Resident # 1 had been					
		lity. She indicated that					
		of paper to document					
		ecks done on Resident #					
		able to provide any of the					
		forms. She stated she					
	1 -	oleted forms were kept in					
		nical record. When CNA					
		nere today's sheet was					
		d there is not one for					
		I guess they ran out of					
		ven't printed anymore.					
	,	I J					
	The PSA [Person	al Service Assistant]					
	_	a-2p, 2p-10p, and 10p-6a					
		n 7/11/11 at 1:15 P.M.					
	The sheets indica						
		he list included the room					
	_	idents. Resident # 1's					
		ted on the risks for					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE COME 07/11/2	LETED
NAME OF PROVIDER OR SUPPLIER MONROE HOUSE			2770 S	ADDRESS, CITY, STATE, ZIP CO ADAMS RD IINGTON, IN47403	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
TAG	elopement. In an interview v at 1:20 P.M., she worked in the fa She indicated the updated for at le This state reside 2/21/11 and 5/9/	with CNA # 1, on 7/11/11 e indicated she had cility for about 2 months. e task sheets had not been ast 2 to 3 weeks. Intial finding was cited on 11. The facility failed to temic plan of correction	l I	CROSS-REFERENCED TO THE AP- DEFICIENCY)	PROPRIATE	DATE

PRINTED: 07/29/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/11/2011
NAME OF PROVIDER OR SUPPLIER			2770 S	ADDRESS, CITY, STATE, ZIP CODE ADAMS RD	
MONRO	E HOUSE		BLOOM	IINGTON, IN47403	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
R0217	facility, using apprenembers, shall ideservices to be profollows: (1) The services or resident shall be a (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services or and revised as appeared and revised as appeared and factoring. Either the request a service (3) The agreed upsigned and dated of the service planteresident upon requestion of the services provided subsequent to the need for a change (5) If administration provision of reside both, is needed, a involved in identification the services to be Based on intervices facility failed to	ffered shall be reviewed propriate and discussed by acility as needs or desires a facility or the resident may plan review. on service plan shall be by the resident, and a copy a shall be given to the uest. In and documentation of its needed if evaluations initial evaluation indicate now in services. In of medications or the ential nursing services, or licensed nurse shall be cation and documentation of provided.	R0217	Citation #2 IDR Request R 410 IAC 16.2-5-2 (e) (1-5) Evaluation We respectfully diagree with this citation and	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 07/11/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2770 S ADAMS RD MONROE HOUSE **BLOOMINGTON, IN47403** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE minimize the risk for exit seeking the Mobility Management interventions. behaviors for those residents Choose only interventions that can considered to be "at risk." Even realistically be accomplished and added to though Monroe House does not the Negotiated Service Plan [NSP]. (The consider resident #1 to be an exit seeker Monroe House has alerts NSP should reflect appropriate monitoring in place such as the updated and interventions.)..." service level assessment and negotiated service plan for this The Resident Services Notes, dated 7/6/11 individual to include services at 4:30 P.M., indicated "Sent to (Name) rendered by our staff to ensure the resident's scheduled and hosp [hospital] ER [emergency room] due unscheduled needs. Resident #2 to fall." was admitted to Monroe House at a base level and was considered The Resident Services Notes, dated 7/6/11 independent with ambulation, medication management, ADL's, at 7:10 P.M., indicated "Return from and IADL's. Resident ambulated (name) hosp. No fx [fracture] L [left] hip without assistive device and had just bruised." a fall on 7/6/11 with an admitting D/X of a bruised hip. Resident has been re-assessed by the The Resident Services Notes, dated 7/6/11 Regional Director of Quality and at 4:35 P.M., indicated "Resident had Care Management with the experienced a fall and was notified by the service plan updated to include family. Upon entry resident was in apt interventions to minimize the risk for falls with injury including a call [apartment] in living room. Resident was pendant that was arranged prior assessed and noted to have pain in L hip. to survey and placed on the day Writer kept resident comfortable and of re-survey by the Regional instructed PSA to contact 911 to have Maintenance Director on 7/11/11. Resident is currently receiving resident transferred to (name) hospital per therapy and is utilizing a walker to family..." assist with ambulation. How the facility will identify other 2. The clinical record for Resident # 1 was residents having the potential reviewed on 7/11/11 at 10:00 a.m. The to be affected by the same deficient practice and what record indicated Resident # 1 indicated corrective action will be taken? diagnoses that included but were not No other residents were found to limited to cognitive deficit. be affected. The Regional Director of Quality and Care

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NAME OF PROVIDER OR SUPPLIER MONROE HOUSE			_	2770 S	DDRESS, CITY, STATE, ZIP CODE ADAMS RD INGTON, IN47403		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	the activity direct person observed resident or not, be new admission at to car. In an interview won 7/11/11 at 11: when Resident # facility talked with instructed them a sign on the door vendors not to as further indicated was new and he physician himsel. A Physician Fax Order, dated 6/30 and writer has obthis residents continued.	tor was not sure if the in the parking lot was a sut she assumed he was a she was going from car with the Regional Nurse, 30 A.M., he indicated 1 eloped on 6/28/11 the th the vendors and not to let residents out the reindicated there had been or to inform visitors and sist residents outside. He Resident # 1's behavior had contacted the			CROSS-REFERENCED TO THE APPROPRI		
	set up in med [m daughter due to de med planner con administering med [urinalysis]?" Adated 6/30/11 at	nedications after being edication] planner by change I have removed tacted family and am eds. May we do a U/A A Fax Error Report, 11:32 (no A.M. or P.M.),					
		:30 P.M., the entry way the posting of a sign to					

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			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
			B. WIN			07/11/2	011
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER			2770 S	ADAMS RD		
	E HOUSE				IINGTON, IN47403		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DETERNOT)		DATE
		ot to assist residents					
		as a sign observed					
	1	e key pad to exit the					
	I -	there was no other signs					
		m visitors upon entering					
	the facility not to	assist residents outside.					
	On 7/11/11 at 1:1	5 P.M., in an interview					
		e indicated Resident # 1					
		ry 30 minutes for his					
		icated these checks had					
		Resident # 1 had been					
		lity. She indicated that					
		of paper to document					
		ecks done on Resident #					
	1 but she was una	able to provide any of the					
	completed check	forms. She stated she					
	thought the comp	oleted forms were kept in					
	the resident's clin	nical record. When CNA					
	# 1 was asked wh	nere today's sheet was					
	located she stated	d there is not one for					
	today. She stated	I guess they ran out of					
	· ·	even't printed anymore.					
		, J					
	The PSA [Person	al Service Assistant]					
	l "	a-2p, 2p-10p, and 10p-6a					
		n 7/11/11 at 1:15 P.M.					
	The sheets indica						
		he list included the room					
	1 -	idents. Resident # 1's					
		ted on the risks for					
		icu on the risks 101					
	elopement.						
	In an interview w	vith CNA # 1, on 7/11/11					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP 07/11/2	LETED
NAME OF PROVIDER OR SUPPLIER MONROE HOUSE			STREET A 2770 S	ADDRESS, CITY, STATE, ZIP CO ADAMS RD MINGTON, IN47403	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	at 1:20 P.M., she worked in the factor of the indicated the updated for at less than the state resider 2/21/11 and 5/9/	e indicated she had cility for about 2 months. e task sheets had not been ast 2 to 3 weeks. Intial finding was cited on 11. The facility failed to temic plan of correction				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM	E SURVEY PLETED /2011
NAME OF PROVIDER OR SUPPLIER MONROE HOUSE			2770 S	ADDRESS, CITY, STATE, ZIP CO ADAMS RD IINGTON, IN47403	ODE	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE IPPROPRIATE	(X5) COMPLETION DATE